DOCUMENT RESUME

ED 351 817 EC 301 635

AUTHOR	Bryant, Brad; Snodgrass, Robert
TITLE	Program Standards for Treatment Foster Care.
INSTITUTION	Foster Family-Based Treatment Association, New York, NY.
PUB DATE	Apr 91
NOTE	38p.
AVAILABLE FROM	Foster Family-Based Treatment Association, 43 W. 33rd St., #601, New York, NY 10001 ($20.00; $15.00 members).
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Agencies; Children; *Disabilities; *Foster Care; Foster Children; Foster Family; Individualized Programs; *Intervention; Placement; Professional Associations; Program Development; Social Services; Staff Development; *Standards; *Therapy
IDENTIFIERS	*Foster Family Based Treatment; Foster Family Based Treatment Association

ABSTRACT

This document provides a guide to quality treatment foster care programming for children with special emotional, behavioral, medical or developmental needs. Treatment foster care meets the needs of such children and their families through implementation of home-treatment plans by foster parents who are trained, supervised, and supported by social service agency personnel. After introductory material about the Foster Family-based Treatment Association which developed the standards and a discussion of the need for such standards, the standards are presented in four sections: (1) agency staff (standards address the case supervisor, case worker, and staff training and support); (2) treatment parents (treatment home responsibilities such as treatment planning, record keeping, advocacy, checks and references, punishment, respite, and damages and liability); (3) children, youth and their families (e.g., placement and support services and treatment planning); and (4) program (program statements and program evaluation). (DB)

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Program Standards

For

Treatment Foster Care

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Acknowledgements

This document is the product of efforts undertaken by a great many individuals and agencies in the United States and Canada. Broadest credit is owing to the member agencies of the Foster Family-based Treatment Association which identified and supported the production of treatment foster care standards as the organization's first major priority following its incorporation. These Standards are the result of an extended process of discussion, debate, compromise and refinement covering a period of several years and involving dozens of FFTA agency representatives in multiple rounds of regional and national meetings including the final summary session held in Washington, D.C. in March of 1991.

A Standards Committee appointed by the FFTA Board of Directors guided the process of development. Co-chaired by Regina Lawrence (Children's Garden) and Robert Snodgrass (People Places, Inc.), the committee's composition fluctuated over time to tap the best thinking of the entire FFTA Board. Association Board members include A. Lynn Avery (Beech Brook Staff Homes), Gerald Bereika (National MENTOR, Inc.), Jay Berlin (Alternative Family Services), Karen Blase (Hull Community Services), Andrea Criste (Father Flanagan's Boys' Home), Karl Dennis (Kaleidoscope), Edward Farmer (Maryville Academy), Nancy Fleming (Youth Homes, Inc.), William Fuser (Lilliput Children's Services), Joyce Goldstein (Child & Family Services of Hartford, Inc.), Patricia Harmon (Human Service Associates), Lillian Ingalls (Washington State Department of Social Services), Bonnie Judkins (BIABH Professional Parenting), Bruce Maag (Specialized Alternatives for Youth of America, Inc.), Pamela Meadowcroft (The Pressley Ridge Schools), Paul Patton, Jr. (Action Youth Care, Inc.), Michael Peterson (PATH), Joan Riebel (Family Alternatives, Inc.), Mark Robinson (Spaulding for Children), and Rosemary Unterseher (The Casey Family Program).

Appreciation is owing to FFTA Advisory Board members who provided counsel, comment and criticism especially in the final stages of Standards preparation. We are particularly grateful for the timely and thoughtful guidance offered by Eileen Pasztor (Child Welfare League of America), Jake Terpstra (Children's Bureau), Emily Jean McFadden (Eastern Michigan University) and James Breiling (National Institute of Mental Health).

This document was organized and written by Brad Bryant and Robert Snodgrass (People Places, Inc.). Our special thanks go to Kathleen Bendewald (Children's Garden) for her summaries and revisions of regional reports which greatly facilitated the completion of these Standards.

FFTA Standards for Treatment Foster Care

Background

THE NEED FOR STANDARDS

Institutional care for persons with special needs continues to be questioned as a long-term or exclusive form of intervention, particularly as it has been employed with children. The system of foster family care which serves hundreds of thousands of children in North America itself was developed in part as a more humane alternative to congregate care in orphanages. The latter half of the 20th century has seen a growing movement advocating similar alternatives for persons with handicapping conditions once considered best addressed in specialized institutional settings. Treatment foster care (TFC) is such an alternative. It is a community-based treatment option grounded in the same values which have guided deinstitutionalization efforts generally for the past several decades.

Treatment foster care is an evolving service. Early efforts in the 1950s and 60s provided enhanced support to foster families and sought primarily to strengthen their capacity to persevere with children whose problems typically proved overwhelming. In these early programs, treatment was viewed as the sole province of professionals who provided it outside the home. Later programs also provided intensive support services to foster families, but saw treatment as occurring primarily in the foster home rather than the therapist's office, with foster families bearing direct responsibility for implementing in-home treatment plans. This distinction is a defining feature of what increasingly is referred to as "therapeutic" or "treatment" foster care.

Attempts to define treatment foster care as a discrete model have paralleled the development of actual programs. An information base including conceptual writings, surveys and limited evaluation research has grown with the size and number of programs describing themselves as treatment foster care. Given the reported efficacy, ethical advantages and economy of the model, its expansion is likely to continue. While treatment foster care will continue to evolve, there is now both the need and the capacity to begin to operationalize its definition in the form of program standards. It is our belief that this task may best be accomplished by those who have developed and continue to operate treatment foster care programs.

THE FOSTER FAMILY-BASED TREATMENT ASSOCIATION-FFTA

FFTA is an agency-led organization of treatment foster care providers established in 1988 with an initial purpose of defining and refining treatment foster care practice. While the Association is assisted by recognized researchers and policy-makers in the fields of child welfare and mental health, its membership is composed entirely of agencies throughout North America currently operating programs of treatment foster care. As such, FFTA is perhaps uniquely qualified to develop TFC program standards.

FFTA member agencies share certain core values and principles which lie at the heart of treatment foster care itself and which shape its operations. These include a strong belief in normalization as a treatment principle and in the power of family living as a normalizing influence. We share a belief in the important role that kinship plays in the formation of identity and self-worth and we support all relationships which impart a sense of family belonging to our children and youth. We believe that all children and youth need and have a right to a permanent family and we support family reunification, adoption, kinship care or other long-term stable family living arrangements to achieve that end. We believe in the value of cultural diversity and in the importance of developing competence in dealing with issues of diversity.

While these values are important to who we are and what we do, they hardly are unique to treatment foster care. Perhaps our most distinctive shared value is a simple but profound commitment to "doing whatever it takes" to maximize a young person's chances to live successfully in a family and community. This is a very practical idealism, one that is demanded by the nature of the task. We serve children and youth who typically are or have been treated in institutional settings, but we do so in broader, less contained, more complex community environments. While the approach offers obvious advantages with regard to normalization and treatment generalization, it also demands that we attempt to anticipate, promote, defend against or otherwise respond to a host of influences either beyond or only marginally in our control. That context has forced a recognition of the fundamental importance of documentation and systematic evaluation of services and their effects.

In treatment foster care, we must deal with much more of the child's world than typically is addressed in traditional residential treatment. To do so effectively, we have had to develop a high degree of flexibility, innovation and responsiveness to individual needs and circumstances. Because we have found that we must, we share a common commitment to individualized care, i.e., to services designed to fit the particular needs of each child rather than the institutional or administrative convenience of the program itself.

FFTA STANDARDS

To bring experienced practitioners together to develop operating standards for treatment foster care has been a primary FFTA purpose since its founding. Discussions aimed at defining a generic model have been the central focus of Association board meetings, conferences and informal gatherings among member agency staff for several years. More recently, these discussions have moved from the level of broad definition to more specific program operations and policy.

Since the fall of 1989, FFTA member agencies have participated in a series of regional meetings held throughout the U.S. and in Canada to propose and debate specific TFC standards. Reports from these regional sessions were collected, summarized and distributed to member agencies for further regional discussions. Input from the final round of regional meetings in the fall of 1990 was discussed and summarized by the Association board in December of that year and a draft prepared for consideration by member agency directors at their meeting in Washington D.C. in March, 1991. Based on their recommendations, a final draft was completed and distributed to members, FFTA advisors and other key individuals in the U.S. and Canada.

The Treatment Foster Care Standards presented here represent the efforts of those currently engaged in the field, many of whom helped pioneer the model. They are minimum standards. As such, they represent what is essential to any program describing itself as treatment foster care. Some current practitioners will meet them all immediately; others will require time and resources to do so. Most aspire to exceed the minimum rather than simply achieve what is acceptable.

Any attempt to set standards for a program type still very much in the process of evolution runs the risk of limiting innovation and further development. The emergence of treatment foster care as a model is itself the result of innovation and creativity; of a willingness to depart from orthodoxy. It is important to recognize that these standards may not cover all successful variations on the treatment foster care theme. The Association intends to revise them periodically to reflect the evolution of practice and the addition of empirical evidence. We urge those who use these standards to evaluate their implementation and effects and to communicate feedback directly to the Association's headquarters.

These FFTA standards aim to provide an operational definition and guide to quality treatment foster care programming. We recognize the thorough and comprehensive efforts of such organizations as the Child Welfare League of America, the Council on Accreditation, the Canadian Child Welfare Association and the American Public Welfare Association in developing standards for foster family care and other broad service models.

The FFTA treatment foster care standards do not attempt to address all content areas covered in more generic program standards. There is no standard, for example, regarding the content or format required for keeping personnel records or recording sick leave since these areas are common to nearly all organizations. Only those functions and content areas which serve to define treatment foster care as a discrete program type are included here.

ORGANIZATION OF THE DOCUMENT

The organization of this document is based on a single key sentence or foundation statement which establishes the essential persons and activities comprising treatment foster care:

> **"Treatment foster care is a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents trained, supervised and supported by agency staff."**

The key sentence is less a definition than a structural framework identifying and linking the major content categories of the four sections in which the standards are presented. These sections are addressed in the following order: **I. Agency Staff; II. Treatment Parents; III. Children, Youth and Their Families,** and **IV. Program.** Section categories and key terms are explained briefly in the introduction to this document.

The sequence in which sections are ordered is based on the notion that persons make a program rather than vice versa. Those sections identified by key person are presented first. The final **Program** section attempts to draw together those elements of organization, policy and evaluation necessary to shape the efforts of the persons involved in treatment foster care into a coherent program. While an effort has been made to avoid redundancy, some repetition has been allowed to promote continuity and easier cross-referencing. Readers will note that while the terms "children" and "youth" are for the most part used together, they occasionally are used singly to streamline sentence structure. When used alone, each term is intended to refer broadly to all young persons from infancy to early adulthood without meaning to suggest that there are no significant differences among persons of different ages and levels of maturity. The terms "family" and "parent", when used without modifiers, are intended to refer to the permanent family members of children and youth in treatment foster care. The terms "treatment family" and "treatment parent" are used in reference to members of a treatment foster family only.

Also to ease reference, individual Standards are numbered in straight sequence from the beginning of the document through the end, regardless of the section, subsection or page on which they appear. Each Standard is italicized and bears a single identifying number.

Treatment Foster Care Program Standards

Introduction

Treatment Foster Care is a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents trained, supervised and supported by agency staff. Each of the key persons and components identified in this statement is essential to any application of treatment foster care as a service model or program type.

A **program** of treatment foster care is a coherent, integrated constellation of services specifically designed to provide treatment within a foster home setting. The term "program" implies a discrete organizational entity with clearly stated purposes and means of achieving them which are logically described and justified within the framework of a consistent treatment philosophy. As a program, treatment foster care is agency-led and team-oriented. It is not simply the provision of higher payment and more training to foster parents for work with more difficult children and youth.

Treatment is the coordinated provision of **services** and use of procedures designed to produce a planned outcome in a person's behavior, attitude or general condition based on a thorough assessment of possible contributing factors. Treatment typically involves the teaching of adaptive, prosocial skills and responses which equip young persons and their families with the means to deal effectively with conditions or situations which have created the need for treatment. The term "treatment" presumes stated, measurable goals based on a professional assessment, a set of written procedures for achieving them, and a process for assessing the results. Treatment accountability requires that goals and objectives be time-limited and outcomes systematically monitored.

Treatment foster care requires **agency staff** who are qualified, trained and supported to implement the model. Some "TFC" initiatives have been undertaken in which one or a few staff with duties in other program areas assume responsibility for additional "treatment foster care" cases. Such arrangements tend to dilute the time, resources and support available to the case worker and to diminish the intensity and focus of the services provided. They generally do not constitute a true program of treatment foster care. A treatment foster care program must have a minimum of two full-time equivalent staff, with one individual clearly tasked with its administration.

Treatment foster care is foster family-based. The **treatment foster family** is viewed as the primary treatment setting, with treatment parents trained and supported to implement the in-home portion of the treatment plan and promote the goals of permanency planning for children in their care. While their role is central to the model, treatment parents do not carry primary or exclusive responsibility for the design of treatment plans. This is a team function carried out under the clinical direction of qualified program staff.

Treatment foster care serves **children and youth** whose special needs cannot be met in their own families and who require out-of-home care. While many TFC programs focus on services to children with serious emotional and behavioral disturbance, the term "special needs" may apply to any clinical problem or handicap — whether of an emotional, behavioral, medical, intellectual or developmental nature. These may include, for example, infants born drug-dependent or testing positive for the HIV virus. In addition to providing treatment for specific problems or conditions, treatment foster care seeks to promote a permanent family living arrangement for the children and youth it serves.

Treatment foster care programs also serve the **families** of the children and youth in their care. TFC programs seek to involve children and families in treatment planning and decision-making as members of the treatment team. They provide family reunification services to children and their families where return home is planned, and actively seek to support and enhance children's relationships with their parents, siblings and other family members throughout the period of placement regardless of permanency goal unless such efforts are expressly and legally proscribed.

Section I: Agency Staff

INTRODUCTION

Professional TFC staff perform several roles and carry a wide variety of responsibilities. Primary among these is their responsibility for treatment planning and for leadership of the treatment team which typically is composed of a case worker, a supervisor or clinical consultant, the child and his/her parents, the treatment parents and other professionals closely involved with the child and family such as therapists or special education instructors. Other major responsibilities required of TFC program staff include but are not limited to case assessment, case management, parent support and consultation, clinical and administrative supervision of staff, 24-hour crisis intervention on-call services, treatment parent recruitment, orientation, training and selection, youth intake and placement, record-keeping and program evaluation. Given the number, range and degree of stress inherent to the performance of TFC staff responsibilities, a true program of treatment foster care cannot be carried out by a single professional staff person. A minimum of two full-time equivalent professional staff, one of whom must be full-time, is required to constitute a program of treatment foster care.

A treatment foster care program must be a separately identifiable unit of a larger agency or be an independent agency itself. To function in this manner, the program must designate an individual responsible for its administration. This individual assumes final responsibility for the provision and oversight of all essential tasks and services described in these Standards within the parameters specified.

While documented performance of the tasks and functions described here is essential, their distribution among program staff will vary according to the size, nature and discretion of individual agencies. Critical responsibilities and minimum qualifications are described below for the positions of Case Supervisor and Case Worker. The responsibilities ascribed to each must be met, but may be allocated differently according to an individual agency's internal organization and staffing. Requirements for training and support pertain to all professional staff.

CASE SUPERVISOR

The role of the Supervisor is to provide support and consultation to the Case Worker in much the same manner as the Case Worker provides support and assistance to Treatment Parents. Specifically, the Supervisor must perform the functions and meet the qualifications stated below.

A. SUPERVISOR'S RESPONSIBILITIES

1. CASEWORK SUPERVISION. The Supervisor will provide regular support and guidance to the Case Worker through weekly supervisory meetings. Formal supervisory meetings will be supplemented as needed by informal contact between Supervisor and Case Worker. Weekly clinical consultation to the Case Worker must be arranged or provided by the TFC program if the Supervisor does not possess the experience and qualifications required to offer such specialized guidance. The Supervisor to Case Worker ratio must not exceed 1 to 5.

NOTE: The Supervisor - Case Worker ratio should be adjusted downward to account for such variables as the severity of the problems presented by youth served or the relative experience/qualifications of casework staff.

2. TREATMENT PLANNING. The Supervisor takes ultimate clinical responsibility for the development of a comprehensive treatment plan based on a thorough case assessment for each child/youth admitted to the program and demonstrates accountability by sign-off on each plan. She or he supervises ongoing treatment planning and implementation for each child, evaluating all quarterly progress reports and treatment plan updates and indicating approval by sign-off.

3. TREATMENT TEAM. The Supervisor oversees and supports the Case Worker as leader of the treatment team and shares ultimate responsibility for team plans and decisions.

4. CRISIS ON-CALL. The Supervisor provides coordination and back-up to assure that 24-hour on-call crisis intervention services are available and delivered as needed to treatment parents, children, youth and families.

B. SUPERVISOR'S QUALIFICATIONS

5. QUALIFICATIONS. The Supervisor must have a graduate degree in a human service field plus a minimum of two years' experience in the placement/treatment of children and families. The Supervisor must be familiar with clinical research and practice to ensure that current empirical findings inform the treatment planning process. If the education and experience of the Supervisor are not recognized as sufficient in the state/province in which the program operates, additional clinical consultation shall be provided. Clinical consultants must be licensed or otherwise recognized as qualified by the state or province in the discipline(s) required for the children served by the program. Such persons may, for example, include MSWs, psychologists, or professional counselors.

NOTE: The experience of treatment foster care providers is that direct experience, personal qualities and skills are at least as important as formal education with regard to staff competence. While the value of formal education is recognized in this standard, so is the value of direct experience in the field.

CASE WORKER

The Case Worker is the practical leader of the treatment team. As such, the Case Worker takes primary responsibility for the development of treatment plans; provides support and consultation to treatment parents, to families of children in care and to other treatment team members related to their role as described in the treatment plan; and advocates for, coordinates and links children/families with needed services available within the TFC agency or in the greater community. Specifically, the Case Worker must perform the functions and meet the qualifications stated below.

A. CASE WORKER'S RESPONSIBILITIES

6. TREATMENT TEAM. Under the supervision of the Case Supervisor, the Case Worker takes primary day-to-day responsibility for leadership of the treatment team. The Case Worker organizes and manages all team meetings. If the Case Worker is prevented from participation in a team meeting by a crisis or personal leave reasons, the supervisor takes over that responsibility. As team leader, the Case Worker manages team decision-making regarding the care and treatment of the child and services to the child's family.

The Case Worker provides information and training as needed to treatment team members designated in the comprehensive treatment plan who may not be familiar with the treatment foster care model. The Case Worker prepares these individuals to work with treatment parents in a manner which is supportive of the treatment parents' role and prepares them to participate in the treatment team in a manner consistent with TFC practice and values. The Case Worker shall take an active role in identifying the goals and coordinating treatment services provided to youth by persons or agencies outside the TFC program whether or not these persons or agencies participate regularly as treatment team members.

7. TREATMENT PLANNING. Under the supervision of the Case Supervisor, the Case Worker takes primary responsibility for the preparation of each child's written comprehensive treatment plan and of quarterly written updates of the plan. The Case Worker signs off on treatment plans and updates. The Case Worker seeks to inform and involve other team members in this process including treatment parents, the child and the child's family.

8. SUPPORT/CONSULTATION TO TREATMENT PARENTS. The Case Worker will provide regular support and technical assistance to treatment parents in their implementation of the treatment plan and with regard to other responsibilities they undertake. Fundamental components of such technical assistance will be the design or revision of in-home treatment strategies including proactive goal-setting and planning, and the provision of ongoing child-specific skills training and problem-solving in the home during home visits. Other types of support and supervision should include emotional support and relationship-building, the sharing of information and general training to enhance professional development, assessment of the youth's progress, observation/assessment of family interactions and stress and assessment of safety issues.

The Case Worker will provide at least weekly contact by phone or in person with the treatment parent of each youth on his/her caseload. The Case Worker will visit the treatment home to meet with at least one treatment parent no less than twice monthly.

NOTE: It is expected that the frequency of home visits will increase substantially beyond the minimum during the initial six weeks of a child's placement, during and immediately after re-placements within the program, during discharge planning, during emergency or crisis situations in which youth are considered at greater risk, and as otherwise required by the child's individual needs/clinical status or the needs of the treatment family.

9. CASELOAD. The number of children/youth assigned to a Case Worker is a function of several variables including the size and density of the geographic area served, the array of job responsibilities assigned, and the difficulty of the population served. The preferred maximum number of youth that may be assigned to a single individual is 10. The caseload size should be adjusted downward if (1) the Case Worker's responsibilities exceed those described under "Case Worker's Responsibilities," numbers 6 through 13, in these Standards, (2) the difficulty of the client population served requires more intensive supervision and training of the treatment parents, or (3) if local travel conditions impede the Case Worker's ability to maintain the minimum direct contact frequencies identified in these Standards.

Some circumstances may allow for a larger maximum caseload size, but in no instance may it exceed 12.

NOTE: Caseload size may be affected by a number of considerations. Special service needs, such as the placement of siblings together, may require the flexibility allowed by a larger maximum caseload. Unusual staffing configurations or service designs - such as a small Supervisor to Case Worker ratio or the use of paraprofessional aides - may enhance and broaden the delivery of support services and allow for caseloads beyond the preferred maximum. Caseloads which include children in long-term care who have achieved a measure of stability in a treatment family but continue to require specialized treatment may be viewed somewhat differently than caseloads comprising only children and youth newly admitted to treatment foster care. Given such considerations, a degree of flexibility is allowed in this Standard.

10. CONTACT WITH CHILD/YOUTH. The Case Worker or other program staff shall regularly spend time alone with children in care to allow them the opportunity to communicate special concerns, to make a direct assessment of their progress, and to monitor for potential abuse. Such face-to-face contact must occur at least twice monthly.

NOTE: While infants also must be seen directly by agency staff according to the above frequency, the "time alone" condition applies on an age-appropriate basis.

11. *SUPPORT/CONSULTATION TO THE FAMILIES OF CHILDREN/ YOUTH. During a child's tenure in treatment foster care, the Case Worker will seek to support and enhance the child's relationships with family members. The Case Worker will arrange for and encourage regular contact and visitation between children and their parents and other family members as specified in the treatment plan. The Case Worker will seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program.*

12. *COMMUNITY LIAISON AND ADVOCACY. Based on a thorough assessment of the child's needs, the Case Worker will determine which community resources are required and how they may be used to meet the objectives of the child's treatment plan. The Case Worker will advocate for and coordinate the provision of such services and will provide technical assistance to community service providers as needed to maximize the benefit of these services to the child.*

13. *CRISIS ON-CALL. The Case Worker together with other professional staff as designated by the agency will be on-call to treatment parents, children and their families on an around-the-clock, 7-day-a-week basis.*

NOTE: While the Case Worker should always be accessible to other treatment team members as needed, primary on-call responsibilities should be distributed among staff so as to allow each Case Worker regular respite from primary and exclusive on-call responsibilities.

B. CASE WORKER'S QUALIFICATIONS

14. *QUALIFICATIONS. The Case Worker shall have at a minimum a B.A. or B.S. degree in a human service field plus two years direct experience working with children and families. An acceptable equivalent to the educational requirement would be a degree awarded through a specialized three-year diploma program in child and youth care or behavior analysis as is offered in some Canadian universities.*

NOTE: Interpersonal skills, judgment, flexibility, commitment and team-work are essential to the position of Case Worker. While assessment/ treatment planning skills and understanding of family styles are equally important, these may be developed through training, supervision and work experience provided by the TFC program.

Few graduate programs currently equip students with knowledge or skills specific to community and family-based treatment. The minimum education requirement reflects the value placed on experience, on-the-job training and personal competence as well as on formal education.

STAFF TRAINING AND SUPPORT

All professional staff require preservice and ongoing professional development relevant to the treatment foster care model and to their individual job responsibilities.

15. AGENCY STAFF DEVELOPMENT. Professional staff shall participate in 20 hours of preservice training prior to assuming casework responsibilities and participate in ongoing training as scheduled by the agency throughout the year. At a minimum, training shall address: an overview of treatment foster care, its history and development; orientation to the agency's treatment philosophy and skill training in the specific treatment methodologies it employs; the use of passive physical restraint; crisis intervention; grief and loss issues for children in foster care and the significance/value of birth families to children placed in treatment foster care; cultural competence and culturally responsive service, and specific agency policies and procedures including documentation and evaluation requirements. Professional staff also must participate in the first available sequence of the agency's preservice training for treatment parents following the start of their employment.

16. CRISIS ON-CALL. The program shall provide on-call crisis intervention support to supplement that provided by the Case Worker to allow for regular respite and to minimize staff burnout.

17. LIABILITY INSURANCE. Professional staff shall be covered by liability insurance.

18. LEGAL ADVOCACY AND REPRESENTATION. The agency shall assist staff in obtaining legal advocacy and representation should the need arise in connection with the proper performance of their professional duties.

Section II: Treatment Parents

INTRODUCTION

The role of the treatment parent is central to treatment foster care. Treatment parents are viewed as colleagues and team members by professional staff. They serve as in-home treatment agents implementing strategies specified in a child's treatment plan. Their responsibilities also encompass all basic parenting duties typically required of foster parents including, for example, the provision of nutrition, clothing, shelter and physical care, nurturance and acceptance of the child in their families, supervision of the child, transportation to needed services and compliance with federal, state/provincial and agency regulations concerning foster parents.

TREATMENT HOME RESPONSIBILITIES

A. THE FOSTERING ROLE

Because of the dual nature of their role and responsibilities, treatment parents must be informed of their responsibilities as foster parents as well as treatment parents as part of their orientation to treatment foster care.

> *19. DESCRIPTION OF RESPONSIBILITIES. Prospective treatment parents must be provided with a written list of duties clearly detailing their responsibilities both as treatment parents and as foster parents prior to their approval by the program.*
>
> NOTE: Foster parent rights and responsibilities may be drawn from the TFC program's state/provincial foster parent certification requirements.

B. THE TREATMENT ROLE

As active agents of planned change, treatment parents are not only caretakers of troubled children; they are integral members of a treatment team. Treatment foster care programs recognize the treatment family as the primary locus of intervention with children and youth in their care and seek to integrate rather than substitute treatment services provided outside the home. Treatment parents are not expected to function independently. They are asked to perform tasks which are central to the treatment process in a manner consistent with the child's treatment plan and the decisions of the treatment team. In addition to their basic foster parenting responsibilities, treatment parents perform the following tasks and functions.

20. TREATMENT PLANNING. The Treatment Parent shall assist the Case Worker and other team members in the development of treatment plans for the child or youth in their care. Treatment parents contribute vital input based upon their observations of the child/youth in the natural environment of the treatment home.

21. TREATMENT IMPLEMENTATION. The Treatment Parent shall assume primary responsibility for implementing the in-home treatment strategies specified in the youth's initial and comprehensive treatment plans and revisions thereof.

22. TREATMENT TEAM MEETINGS. The Treatment Parent shall work cooperatively with other team members under the leadership of the Case Worker and attend team meetings, training sessions and other gatherings required by the program or by the child's treatment plan.

23. RECORD KEEPING. In order to allow tracking and evaluation of services provided in the treatment home and of the agency's program as a whole, the Treatment Parent shall systematically record information and document activities as required by the agency and the standards under which it operates. When relevant to the treatment plan, the Treatment Parent shall keep a systematic record of the child's behavior and progress in targeted areas on at least a weekly and, preferably, a daily basis.

24. CONTACT WITH CHILD'S FAMILY. The Treatment Parent shall assist the child in maintaining contact with his/her family and work actively to support and enhance these relationships, unless contraindicated in the youth's treatment plan.

25. PERMANENCY PLANNING ASSISTANCE. The Treatment Parent shall assist with efforts specified by the treatment team to meet the child's permanency planning goal(s). Such efforts may include emotional support, advice, and demonstration of effective child behavior management and other therapeutic interventions to the child's permanent family, as well as the provision of support to the family and child during the initial period of post-TFC placement.

26. COMMUNITY RELATIONS. The Treatment Parent shall develop and maintain positive working relationships with service providers in the community such as schools, departments of recreation, social service agencies, and mental health programs and professionals.

27. ADVOCACY. The Treatment Parent, in concert with the agency Case Worker and other staff, shall advocate on behalf of the child to achieve the goals identified in the the child's treatment plan, to obtain educational, vocational, medical and other services needed to implement the plan, and to assure full access to and provision of public services to which the child is legally entitled.

28. NOTICE OF REQUEST FOR CHILD MOVE. Unless a move is required to protect the health or safety of the child or other treatment family members, the Treatment Parent shall provide at least 14 days' notice to program staff if requesting a child's removal from the home so as to allow a planful and minimally disruptive transition.

C. TREATMENT PARENT QUALIFICATIONS AND SELECTION

Treatment parent selection is a process which begins with the initial recruitment contact and extends through parents' orientation and training. Treatment parents are selected in part on the basis of their acceptance of the program's treatment philosophy and their ability to practice or carry out this philosophy on a daily basis. They must be willing and able to accept the intense level of involvement and supervision provided by the TFC program in their treatment parenting functions and the impact of that involvement on their family life. Treatment parents must be willing to carry out all tasks specified in their TFC program's job description including working directly and in a supportive fashion with the families of children placed in their care.

In the selection of prospective treatment parents, several important qualities should be sought. These may include, but are not limited to, commitment, positiveness, willingness to implement treatment plans and follow the program's treatment philosophy, a sense of humor, enjoyment of children/youth, flexibility, tolerance and the ability to adjust expectations concerning achievement and progress to children's individual needs and capabilities. Treatment parents need to approach the commitment to work with a child as a family commitment, informing their own children of the nature of the program and the children it serves and involving them closely in the decision to function as a treatment family. Treatment families should be financially stable and demonstrate emotional stability individually and as a family unit. Single treatment parents should have access to a reliable back-up and network of support.

Treatment parent selection criteria should apply to all treatment parents including respite parents and should include, at a minimum, the following.

29. *LICENSING/CERTIFICATION. All treatment parents must meet all state/provincial social service, mental health, or other applicable standards for licensed foster parents appropriate to the service provided. An initial assessment or "home study" of each treatment family must be conducted which covers all elements required by state/provincial licensing regulations. The assessment will include the family's ability to meet the special needs of the children/youth served by the TFC program.*

30. *CHECKS AND REFERENCES. A criminal records check and child abuse registry check (if available in the program's state/province), must be completed for each Treatment Parent. A minimum of three non-relative references (e.g., employer, school, family physician, local clergy) shall be collected by the program on each Treatment Family. If a prospective Treatment Parent has served previously as a licensed foster parent for another agency(ies), references must be obtained from that agency(ies) as well.*

31. *LANGUAGE. At least one Treatment Parent must demonstrate effective communication in a language of the child in the treatment family's care, and in a language of the program/treatment team with which they work.*

32. *AGE. Treatment Parents must be at least 21 years of age.*

33. *HEALTH. The physical health of Treatment Parents must be equal to the stress inherent in the care of a special needs child/youth as evidenced by a physician's statement to that effect.*

34. *TRANSPORTATION. Treatment parents must have access to reliable transportation. If using a car, they must have a valid driver's license and document ownership of liability insurance as required by their state/province.*

35. *PHYSICAL PUNISHMENT. Treatment Parents must agree not to use physical punishment with children placed in their care and to adhere to the agency's policies regarding the use of punishment generally.*

D. TREATMENT PARENT TRAINING

Training of Treatment Parents shall be a systematic, planned and documented process which includes competency-based skill training and is not limited to the provision of information through didactic instruction. Training must be consistent with the program's treatment philosophy and methods and must equip treatment parents to carry out their responsibilities as agents of the treatment process.

At a minimum, all treatment parents including both partners of a couple and respite parents must meet the following training requirements.

36. PRESERVICE TRAINING. Prior to the placement of children in their homes, all Treatment Parents must satisfactorily complete 20 preservice hours of primarily skill-based training consistent with the agency's treatment methodology and the service needs of the children.

NOTE: Time spent completing the program's orientation or home study/assessment process may not be considered as part of this training requirement.

37. INSERVICE TRAINING. A written professional development plan shall be on record in each agency which describes the content and objectives of inservice training for all agency Treatment Parents. All Treatment Parents must satisfactorily complete a minimum of 24 hours of inservice training annually based on the training needs identified in the agency's professional development plan and the specific services Treatment Parents are required to provide. Inservice training should emphasize skill development as well as knowledge acquisition and may include a variety of formats and procedures including in-home training provided by agency casework staff.

NOTE: Case management in treatment foster care is not limited to emotional support, information sharing and advice. In-home, child-specific training is an integral part of the technical assistance provided to Treatment Parents by Case Managers.

38. EVALUATION OF TRAINING. All Treatment Parents must be provided an opportunity to evaluate mandated training.

E. TREATMENT PARENT SUPPORT

Treatment foster care programs are obligated to provide intensive support, technical assistance and supervision to all treatment parents. Treatment parents shall be provided such support and assistance including the specific case management and supervision services described in Section I above. Additional types of support and support services shall include the following.

39. INFORMATION DISCLOSURE. All information the TFC program receives concerning a child to be placed with a treatment family shall be shared with and explained to the prospective family prior to placement. Agency staff will discuss with the prospective Treatment Parents the child's strengths and assets, potential problems and needs, and initial intervention strategies for addressing these areas. As full treatment team members, Treatment Parents have access to full disclosure of information concerning the child. With this access goes the responsibility to maintain agency standards of confidentiality regarding such information.

40. RESPITE. Treatment Parents shall have access to both planned and crisis respite care for their treatment foster children in homes which have been selected and trained according to the standards for Treatment Parents described in this document. Respite providers must be informed of the youth's treatment plan and supervised in their implementation of the in-home strategies it specifies.

41. COUNSELING. Treatment Parents and their children shall have access to counseling and therapeutic services arranged by the TFC program for personal issues/problems caused or exacerbated by their work as Treatment Parents. Such issues may include, for example, marital stress, or abuse of their own child(ren) by a child placed in their care by the TFC program.

42. SUPPORT NETWORK. The TFC program shall facilitate the creation of formal or informal support networks for its Treatment Parents as, for example, through the coordination of parent support groups or Treatment Parent "buddy" systems.

43. FINANCIAL SUPPORT. Agency financial support to Treatment Parents must cover the cost of care as well as payment for the difficulty of care associated with their treatment responsibilities and the special needs of the children they serve.

NOTE: The additional financial support given to Treatment Parents over that provided parents in the foster family care system at large is directly related to the special skills, functions and responsibilities required of them in fulfilling their role as Treatment Parents.

44. *DAMAGES AND LIABILITY. The program must have a written plan concerning compensation for damages done to a treatment family's property by children placed in their care. This plan must be given and explained to prospective Treatment Parents as part of their preservice orientation. The agency must provide or assist Treatment Parents in obtaining liability coverage. Treatment Parents are required to document that they carry home/apartment, automobile (if they have a motor vehicle), property and liability insurance themselves in addition to any liability and damage coverage provided by or through their TFC program.*

45. *LEGAL ADVOCACY. The agency shall assist Treatment Parents in obtaining legal advocacy for matters associated with the proper performance of their role as Treatment Parents.*

F. TREATMENT HOME CAPACITY

46. *TREATMENT HOME CAPACITY. Given the challenging nature of the children/youth served in treatment foster care and the intensity of services required, the number of children placed in one treatment home shall not exceed two without special justification. Such justification may include the need to place a sibling group, or the extraordinary abilities of a particular family in relation to the special needs of a particular child. Treatment Parents have the right to refuse placement of any child they feel is inappropriate for the home or the safety of children currently in the home.*

NOTE: It is rare that more than two treatment foster children can be served effectively in a single treatment home especially if placed close together in time or in a treatment home which also provides foster care to other children. Programs should consider such variables carefully in decisions regarding a treatment family's capacity and assume a conservative bias in such decisions. The special justification for placement of more than two children in a treatment home should be explained in children's initial treatment plans and in further detail in comprehensive treatment plans to show how these plans and the strategies they describe may be carried out effectively despite the additional demands on the treatment family created by multiple placements.

Section III: Children, Youth and Their Families

INTRODUCTION

Treatment foster care exists to serve children and youth whose special needs are severe enough that in the absence of such programs, they would be at risk of placement into more restrictive residential settings such as hospitals, psychiatric centers, correctional facilities or residential treatment programs. Treatment foster care also aims to serve the families of young persons, supporting child-family relationships and, consistent with individual permanency goals, promoting family reunification or alternatives in which children and youth are connected to relationships intended to last a lifetime.

The types of special needs that young persons in treatment foster care exhibit may include a variety of causes, conditions and diagnostic categories. Treatment foster care programs typically serve youth with problems of emotional/behavioral disturbance, psychiatric diagnoses, delinquency, developmental disorders, intellectual retardation or medical disorders. While there are few, if any, special needs that may not be addressed in treatment foster care given adequate resources, the safety of the children/youth served, the treatment families serving them and the communities within which services are delivered must be considered in admissions and placement decisions and addressed, as relevant, in individual treatment plans.

As opposed to professional staff and treatment parents (Sections I and II) who provide treatment foster care services, children, youth and their families are service recipients. Treatment foster care programs have special obligations to the young persons and families they serve. The primary focus of Standards for treatment foster children and their families is on their rights as service recipients.

Children and youth in treatment foster care and their families have a right to services designed to promote independence. Services to children and youth should target not only the remediation of specific referral problems, but also address their needs in all the major developmental theaters associated with successful independent living. Insofar as they are willing and able, young persons and their families have the right to participate in decisions about what and how services will be provided to them. They have a right, finally, not to be viewed or treated in isolation from each other.

These rights begin prior to the child's formal placement into a treatment family, continue through his/her direct involvement in treatment and other services while in the program, and extend into the period following TFC placement. Specifically, they include the following.

PLACEMENT AND SUPPORT SERVICES

Children, youth and their families have the right to receive all support services described under Sections I and II above. They also have the right to be adequately prepared for the child's placement into a treatment family, to be involved in the placement decision, for the child to be "matched" with the treatment family which best meets his/her needs, and to receive support in maintaining and enhancing their relationships with each other.

47. *PRE-PLACEMENT VISITS. Children/youth referred to treatment foster care should have at least one overnight visit with the treatment family with whom they are placed prior to their admission to the program. Unless contraindicated, the families of young persons to be placed shall be given the opportunity to meet with their child's prospective Treatment Parents prior to placement.*

48. *PLACEMENT DECISIONS. Children, youth and their families shall be consulted as to their preference for placement with specific treatment families whenever possible and appropriate.*

NOTE: Children and youth generally should have the right not to be placed into a treatment foster program or with a specific treatment family if that is their preference. Where the child's and/or the family's preferred option(s) is not possible or is not considered to be in the child's best interest, any other preferences they may express should be considered as major factors in placement decisions.

49. *MATCHING. Placement will be made only after a careful consideration of how well the prospective treatment family will meet the child's needs and preferences and will represent a reasonable "fit" for the child. Important matching variables include, but are not limited to:*

a. Treatment family composition, willingness and ability to work with the child's family.

b. Treatment family's ability to speak a language of the child.

c. Ethnicity, race and culture. Same-race, same-culture placement should be given first priority. If such matches are not possible and cross-placement is considered necessary to serve a child's fundamental human needs, the treatment family must receive training in cultural and physical care issues related to the child's race and culture prior to the child's placement and throughout the duration of his/her stay in the home. There must be a plan to connect these children and youth with other children, youth and adults in the community who share the same culture, race and ethnicity.

d. Proximity to the child's family when appropriate.

e. Local availability/access to resources required to meet the child's needs.

f. Treatment Parents' specific skills, abilities and attitudes needed to work effectively with the particular child to be placed in their care.

50. ASSESSMENT AND RECORDS. To achieve sound placement decisions and planning for relevant treatment services to children/youth, program staff must receive and review the following case material prior to a child's admission: current case plan(s), social history information, previous and current (within a year of referral date) psychological assessments, school information, medical information, previous placement history and outcomes, potential problems and information on the child's/youth's skills, interests, talents and other assets.

For youth admitted to treatment foster care, an individual case record will be kept which includes the above information as well as the following:

a. Personal identifying information such as a birth certificate

b. A pre-admission psychological evaluation (if available)

c. A child social and family history

d. Educational history including school reports and available standardized test results

e. Medical information including sight, hearing and dental exam reports, current medications and allergies, child's physical description, immunization records, medical history and Medicaid/SSI number, if applicable

f. Authorizations for routine and emergency medical care, dental care and other medical procedures

g. Authorizations required by the program's state/province such as authorization for out-of-state/province travel, participation in special activities, publicity releases, etc.

h. Correspondence with/from agencies involved with the child

i. The initial treatment plan

j. The comprehensive treatment plan

k. Progress reports

l. Case notes including contacts with the child's family/extended family

m. Incident Logs or Records on serious behavior problems, illnesses or injuries

51. CHILD'S ACCESS TO AGENCY STAFF. *Treatment foster children/youth shall have access to designated program staff at all times to discuss concerns including any problems they are experiencing in/with their treatment family. Agency staff will provide regular face-to-face contact alone with each child on at least a twice monthly basis.*

52. CHILD-FAMILY CONTACT/RELATIONSHIPS. *Unless specifically proscribed by court or custodial agency decision, treatment foster children/youth shall have access to regular contact with their families as described in the treatment plan. The TFC program shall work actively to support and enhance child-family relationships and work directly with families toward reunification where that is the goal of placement. Specific activities to be undertaken in this regard shall be described in the child's treatment plan.*

53. RIGHTS OF CHILDREN AND YOUTH IN TREATMENT FOSTER CARE. Children in treatment foster care have the same basic rights as all foster children including the right to privacy, to humane treatment, to adequate shelter, clothing, nutrition, essential personal care items and allowances, and to access to religious worship services of their choice. The program shall explain to each child what his/her rights are in a manner consistent with the child's level of understanding and make this information available to the child in writing.

TREATMENT

Treatment foster children/youth have the right to receive direct treatment and related services planned to ameliorate the specific problems associated with their placement in treatment foster care and which address their emotional, cognitive and physical needs in major developmental arenas. Treatment assumes written plans with clearly specified procedures and services designed to achieve measurable goals within a set period of time and with regular assessment of progress. Treatment plans and the methods they prescribe should be based wherever possible on research findings which support their use and efficacy.

Treatment planning is an ongoing process with several characteristics and products. An initial treatment plan completed by the time of admission is needed to guide treatment parents' early assessment and relationship-building efforts and to describe specific responses to potential problems identified through pre-admission assessment. A more comprehensive treatment plan is needed after admission to describe long-term treatment and permanency planning goals and the services to be provided to meet those goals. The comprehensive treatment plan also must address specific strategies to be employed by treatment parents in the home to meet long-term goals and to achieve short-term objectives related to current problems or treatment issues. Significant revisions or extensions of these specific treatment strategies must be documented at least quarterly along with progress on long and short term goals.

Treatment planning should seek to involve the child/youth from the outset and to increase/maximize that involvement over time. The process likewise should attempt to involve the young person's family and to address strategies to promote reunification or to enhance/maintain child-family relationships. Planning should extend beyond the period of a child's tenure in treatment foster care to guide and stabilize transitions to subsequent settings and to maximize the transfer and maintenance of treatment gains. Aftercare services must be addressed as an integral component of the treatment planning process.

At a minimum, treatment planning should include the following.

54. *INITIAL TREATMENT PLAN. An initial written treatment plan shall be completed by the time of the youth's admission to the program. The plan shall describe specific tasks to be carried out by the treatment team during the first 30 days of placement. It shall describe strategies to ease the child's adjustment to the treatment home and to directly assess the child's strengths, skills, interests and needs for treatment within the home. The initial plan should address short-term goals for the first 30 days of placement, identify potential problems likely to be encountered with the child and specify how the treatment team is to respond to them. The initial plan should provide a rationale for the youth's placement in the particular treatment home chosen as a suitable match and identify the youth's long-term permanency plan.*

55. *COMPREHENSIVE TREATMENT PLAN. A written comprehensive treatment plan shall be completed for each youth admitted within 30 days of admission addressing the long-term goals of treatment including criteria for discharge, projected length of stay in the program, projected post-TFC setting and aftercare services. It shall address the child's permanency plan, adhering to the requirements of PL 96-272 (in the U.S. only) regarding the goals of placement. The plan shall identify and build on the child's strengths and assets as well as respond to presenting problems. It shall assess the child's needs for services in major developmental arenas, describing goals and strategies as necessary to promote prosocial, adaptive behavior, emotional well-being, cognitive development, interpersonal skills and relationships, self-care and daily living skills and, particularly for older youth and those remaining in TFC for longer periods, the development of independent living skills. The comprehensive treatment plan shall include proactive short term treatment goals which are measurable and time-limited along with specific strategies for promoting and regularly evaluating progress.*

Children/youth and, unless contraindicated, their families shall be encouraged to participate in assessment, goal-setting and planning as members of the treatment team. If consistent with the child's permanency goal, the treatment plan shall address efforts to be made with the young person's family during and after TFC placement to maintain and enhance child-family relationships and to promote family reunification. If a family is not involved in the treatment process, the program shall document the reason in the comprehensive treatment plan. The treatment planning process should encompass the fundamental aim of increasing the child's and, if appropriate, the family's skills and resources for self-direction, self-management and responsible interdependent living.

The comprehensive treatment plan shall identify all team members who will assist in the provision of planned services, describing how and by whom those responsibilities are to be carried out in clear, concrete and specific language. While treatment may occur on a number of levels and in several settings, the primary prescriptive focus of the plan shall be on the role and specific responsibilities of the treatment family. Treatment Parents must provide input and feedback to the development, revision and evaluation of treatment plans as well as carry out the specific in-home strategies described therein.

56. QUARTERLY PROGRESS REPORTS/UPDATES. Each child's/youth's treatment plan shall be specific, reviewed via quarterly reports and revised as necessary. Quarterly reports shall document progress on specific short term treatment goals, describe significant revisions in goals and strategies, and specify any new treatment goals and strategies initiated during the period covered. The quarterly progress report shall summarize progress and note changes regarding long-term placement and treatment goals.

57. AFTERCARE PLAN. All planned discharges from treatment foster care will be reviewed and discussed by the treatment team, including the child/youth and family. An aftercare plan shall be prepared and ready to be implemented for each child prior to his/her planned departure from the program. The plan shall specify the nature, frequency and duration of aftercare services to be provided to the child/youth and to his/her family and designate responsibility for service delivery. The TFC program shall provide these aftercare services directly or provide consultation as needed to the person/agency assuming responsibility for working with the youth following his/her discharge from the program. An aftercare plan also shall be developed in a timely fashion for children whose discharge is not planned, with follow-up services provided or assisted as described here.

Section IV: Program

INTRODUCTION

The foregoing sections of this document have described standards relating to the essential services which define treatment foster care, the qualifications and responsibilities of those who deliver the services, and the rights of those who receive them. A program of treatment foster care is created when these services and the persons who participate in their delivery are organized in a coherent manner for a common purpose. Such organization requires a comprehensive program statement to shape and guide its operation. A quality program of treatment foster care is made possible when the organization and its parts are subjected to regular self-examination. A sound program of treatment foster care requires a clear Program Statement and a system of periodic Program Evaluation.

PROGRAM STATEMENT

Any human service program must develop a program statement of some kind which describes its administrative structure, policies and procedures. Treatment foster care programs must have a program statement which, in addition to content areas required by their licensing or other administrative authority, must include the following.

> *58. PROGRAM STATEMENT. All treatment foster care programs must have a written program statement which describes its mission, organization structure, services, policies, record-keeping and evaluation procedures. The program statement must describe:*
>
> > *a. The agency's treatment philosophy and the specific treatment modality(ies) it employs.*
> >
> > *b. The services the program provides.*
> >
> > *c. The children it is designed to serve with regard to age, gender, geographic service area and types of special needs the program is prepared to address. Clients served must exhibit an identifiable special need.*
> >
> > *d. A staffing pattern which allows for the intensity of service required in treatment foster care, provides for at least one full-time professional staff and a total of two full-time equivalent staff, and designates an individual responsible for program administration.*

e. An assertion of the program's commitment to being representative of the community in which it serves, reflecting the cultural diversity of that community in the composition of its staff and treatment parent population.

f. A policy statement committing the program staff and Treatment Parents to practices that respect and promote positive birth family connections and positive cultural or ethnic identity.

g. A policy which affirms that the primary use of behavior management strategies will be to teach prosocial, adaptive behavior rather than simply to reduce or eliminate undesirable behavior.

h. A policy on the use of medication which commits the agency to the following principle and practice:

> *1) The first line of intervention with children and youth should be non-medical unless clear research evidence indicates otherwise for a particular condition. When psychotropic medications are recommended by a physician, they should be used in concert with other interventions where such interventions may also contribute to remediation of the problem or safely reduce reliance on medication alone;*
>
> *2) Treatment Parents will be trained in detecting side effects of any medication prescribed for use by children in their care.*

i. A policy on discipline/punishment which includes a description of acceptable methods of control and discipline, a prohibition of corporal punishment, and a discussion of specific types of punishment which are unacceptable. Unacceptable punishment procedures include the loss or threat of loss/restriction of a child's contact with his/her parents, the denial or threat of denial of mail sent to the child, threats of removal from the treatment home, threats of physical harm, and denial or threats of denial of basic needs including meals.

j. A policy on the use of physical restraint prohibiting the use of mechanical restraint or seclusion (e.g., in a locked room) and stating that passive physical restraint is justified only to protect the child or others from injury or to prevent serious damage to property. The policy shall further state that if necessary and justified, physical restraint will be used only by persons who have been trained in its use and will not be employed as a punishment.

k. A plan for back-up emergency care in the event that a child's placement in a treatment family or in the program itself should fail.

l. A written protocol for investigating, responding to and reporting allegations of misconduct toward children by Treatment Parents or other children.

m. A policy statement providing for the immediate removal of a child from a treatment home when there is suspicion that the child may be in danger there.

PROGRAM EVALUATION

Evaluation is essential for programmatic self-knowledge, self-improvement and accountability. Information concerning service delivery and impact must be collected, reviewed and analyzed to maintain, improve and document sound treatment foster care program operations. Such information will be needed for subsequent review and revision of these Standards themselves. At a minimum, TFC program evaluation efforts should address the following.

59. DOCUMENTATION OF SERVICE DELIVERY. A treatment foster care program must clearly document delivery of all services described in its program statement as well as compliance with all minimum operating standards described above.

60. INDIVIDUAL TREATMENT. Treatment foster care programs must document the implementation of all treatment plans and track progress on all long and short-term treatment goals throughout each child's/youth's tenure in care.

61. *FOLLOW-UP TO INDIVIDUAL TREATMENT. TFC programs shall track children/youth discharged from their care for at least one year following their exit. Information collected shall include the nature of the young person's living environment, employment, involvement in training or education programs and current status with regard to major in-program treatment goals.*

62. *PERFORMANCE EVALUATIONS. Programs will provide Treatment Parents and professional staff written performance evaluations at least annually which include descriptive assessments of their performance of specific job responsibilities and goals for improved performance.*

63. *PROGRAM EVALUATION. TFC programs shall have a program evaluation plan which describes information to be collected, summarized and analyzed at least annually. The plan will identify who will have access to the evaluation and how it will be used. The evaluation shall include demographics on current children, youth and their families, treatment families and professional staff; aggregated information describing in-program events such as placement disruptions; and a summary of information collected through follow-up tracking of children/youth discharged from the program. The plan also will provide for periodic evaluations of program services by Treatment Parents, children/youth and their families.*

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